Medicare Part D/Medicare Advantage
RELEASE OF LIABILITY

Senior Health Insurance Information Program (SHIIP) counselor, _____, is aiding me in completing my

(Check box/es that apply)

☐ Medicare Prescription Drug Plan Enrollment Form
[Drug plan selected by applicant_____]

☐ Medicare Advantage Plan Enrollment Form
[Drug plan selected by applicant_____]

☐ Application for Help with Medicare Prescription Drug Plan Costs

I understand that the SHIIP counselor's role is only to provide assistance in completing the relevant forms and that the SHIIP counselor is not reviewing the forms for accuracy.

I understand that it is my sole responsibility both to provide the information required to complete the forms and to assure the accuracy of the information provided. I certify that I provided to the SHIIP counselor the information necessary to complete the forms and further certify that the information I provided is true and correct to the best of my knowledge. I agree that I will not hold the State of Iowa and SHIIP, its management, employees, and volunteers responsible for the denial of benefits or the wrongful receipt of benefits as a result of completing and submitting these forms.

I have read this document fully and carefully and I have had the opportunity to ask questions regarding this document. I am voluntarily choosing to sign this document.

_____
(Beneficiary's name—please print)

_____
(Beneficiary's signature) (date)

_____
(Representative's signature, if applicable) (date)

(Original—to SHIIP office; Copy—to client)